

Workers' health intersectorality: old questions, new perspectives?

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Abstract *The construction of Workers' Health (WH) intersectorality, while fundamental, has been a challenge for this field of knowledge and practice. This paper aims to present and discuss how intersectorality is addressed in WH public policies, in what contexts it is used, how it is defined, and the guidelines for its implementation. This is qualitative documentary research that analyzed documents enacted between 1986 and 2015, accessed through the databases of the Ministries of Health, Labor and Social Security, and the websites of FUNDACENTRO and the National Association of Occupational Medicine (ANAMT). There is clear leadership of the health sector in the documents proposing the construction of intersectorality. Terms such as "integrated actions", "articulation", "dialogue", and "integration", and finally, "intersectorality" were used sometimes as synonyms or conceptual advances, and generic, polysemic, and supposedly consensual expressions. Despite the developing concept of intersectorality in the policies of this field and the growing participation of the different sectors in this construction, few clear propositions about the effectiveness of this practice among managers and workers underlying the field are observed.*

Key words *Worker Health, Intersectorality, Public Health Policies*

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Introduction

Workers' Health (WH), through multiple actions, aims to favor the protection, promotion, recovery, and rehabilitation of the health of workers subjected to occupational risks and injuries^{1,2}. It is a complex and challenging field of practice and knowledge, as it has technical, political, social, and economic dimensions that are inseparable, and it is a necessarily intersectoral field. This paper aims to present and discuss how the concept of intersectorality is addressed in WH public policies, in which contexts it is used, how it is defined, and whether there are clear guidelines for its implementation in the daily practice of services linked to the field³.

It is necessary to revive historically the practices that involve the field of health and work in Brazil to understand the origin and reasons for such challenges. Minayo-Gomez and Thedim-Costa⁴ argue that, despite conceptual advances brought by Workers' Health, actions focused on the relationship between health and work upheld the hegemony of the principles of Occupational Medicine and Health, which now appear obsolete because of their biological nature and for being focused on the prevention of occupational risks. The authors point out that interventions in the workplace were under the responsibility of the Health sector since the early twentieth century, with emphasis on the Carlos Chagas Reform in 1923. However, this function became the Ministry of Labor, Industry, and Commerce's responsibility in 1930, after its creation⁴.

Between comings and goings, creation, merger, and separation of the Ministries and attributions of each, the movement of integration between the sectors involved in health and safety at work actions gained strength from the debates started with the democratization of the country. The First National Conference on Occupational Health (CNST), the Eighth National Health Conference (CNS), in 1986, followed by the 1988 Constitution and the construction of the Brazilian Unified Health System (SUS) in 1990 (regulated in Law 8080/90) stand out as essential milestones in this process.

In this context, from the deliberations of the Second CNST, in 1994, the Ministry of Health should effectively assume all actions in WH and articulate the process of integrating various services at the municipal, state, and federal levels^{5,6}.

The health sector's historical role in the search for advances in workers' health policies is undeniable, including the organization of national

thematic conferences, preparation of documents, and public policies. However, this progress has not ensured the realization of intersectorality as an integrated practice that impacts and favors improvements in working conditions, disease prevention, consolidation of workers' rights, or ensures treatment, rehabilitation, and return and permanence at work programs for those who have already fallen ill⁷⁻⁹.

In 2005, The Ministries of Health (MS), Social Security (MPS) and the currently called Ministry of Labor (MT) published Ordinance N° 800 that gave rise to the National Occupational Health and Safety Policy (PNSST), approved by the Civil House of the Presidency of the Republic¹⁰, in order to build complementary and correlate actions.

Subsequently, the National Workers' Health Policy (PNSTT) was published by the MS in 2012, which, in dialogue with the PNSST, aims to promote health and improve the quality of life of workers and prevent accidents and harm to health somehow related to work, by eliminating environmental risks and modifying work processes².

It is noteworthy that, besides WH, the issue of integration between sectors underpinning public policies is the subject of several debates. Ornelas and Teixeira¹¹ point out that the term "sector" can be understood as "an isolated grouping of social roles, working vertically and autonomously, submitted to the State's attempted regulation". Thus, each sector is limited to a domain of activity or professional logic consisting of ideas and practices in that domain.

Regarding intersectorality, Koga¹² highlights that it is a necessary quality for the intervention process in complex situations, as is the case in the field of health and work. Programs, projects, and technical teams are challenged for dialogue and joint work aimed at social inclusion¹².

Silva et al.¹³ emphasize the polysemy of the word intersectorality, the term's multiple configurations, and the variety of research questions that can be triggered from it, starting to name it "*IntersectorialidadeS*". The authors highlight the existence of significant bibliographic production on the theme, focusing, above all, on the conceptualization of the term and little on its operationalization in daily practices, be they of care or any other nature. They understand intersectorality as a device, a strategy for improving the efficiency and effectiveness of public management by fostering meetings, listening, and otherness, explaining divergent interests, tensions, and seeking (or reaffirming the impossibility) of possi-

ble convergences. It also favors the avoidance of duplicated actions and facilitates the budgetary integration of projects, articulating resources, ideas, and talents¹³.

Several authors emphasize that the incorporation of intersectorality in public policies promotes the articulation of knowledge, helping specialists integrate collective agendas and share common objectives^{12,14-17}. Thus, rather than the combination of institutions and different spheres of the public sector, knowledge, experiences, and practices that can leverage resources available on the network and in the territories are articulated. Unlike the idea of joining resources, it is necessary to share worldviews, interests, and common objectives^{15,18}.

Therefore, intersectorality suggests solving individual needs, ideas of integration, territory, and equity. It facilitates an expanded understanding of planning, implementation, and control of service provision to guarantee equal access to the population¹⁹. However, the specialized literature has shown that, in practice, it raises conflicts and political disputes between the different areas and actors involved in related practices¹⁶.

In the case of WH, it is essential to point out that the boundaries between the responsibilities of the various Ministries involved in the theme have changed over time, sometimes grouping actions and functions, and then dismembering them. From 1986 to date, the MT has been called Ministry of Labor and Federal Administration, Ministry of Labor and Social Security, and Ministry of Labor and Employment (MTE). The MPS created in 1974 becomes, in 2015, the Ministry of Labor and Social Security. In 2018, only the Social Security Secretariat and the National Social Security Institute (INSS) remained after its break up in 2016, and Social Security was transferred to the Ministry of Finance.

The different institutions, besides buildings and administrative organizations, are made of social relationships and knowledge. This challenges us to overcome political-legal norms and warns of the need for dialogues for the construction and consolidation of common objectives^{18,20-22}.

Sposati¹⁴ affirms that intersectorality requires changes in management processes so as not to be considered antagonistic or substitutive for sectoriality, but instead complementary when combining sectoral and intersectoral policy, without countering them in the management process¹⁴. In other words, it would consist of achieving some unity, despite the different areas of activity of the sectors involved, establishing intentional

links that overcome fragmentation and specialization¹⁷.

While the idea of intersectorality has been gradually constructed and consolidated, and advances are significant in the political-legal sphere, in the case of WH, the implementation of intersectoral and integrated practices has been incipient, a situation that challenges the overcoming of the sectorial model, considering the intricacy of the object in question^{7,13}.

Methods

This paper is the result of analytical, qualitative, documentary research. We analyzed documents enacted from 1986 to 2015, collected from the databases of the Ministries of Health, Labor and Social Security, and the websites of FUNDACENTRO and the National Association of Occupational Medicine (ANAMT).

We opted to start the collection in 1986 as it was a period of strong mobilization related to the country's re-democratization process, which culminated in the promulgation of the new Constitution and the creation of the Unified Health System (SUS), in 1988 and 1990, respectively. Also, at this time, we see the emergence of the movement of professionals linked to workers' health. We chose 2015 to finalize the collection, due to the instability that occurred the following year with the change of government, characterized by unpredictable future of current policies.

We sought to gauge longitudinally how the concept of intersectorality (and related terms) was used in WH policies to observe their development and operationalization in the different periods. We sought to understand, albeit not exhaustively, how the theme of intersectorality has evolved in recent years in the health sector, and how it appears in current documents. While a chronological reading was not sought, we attempted to respect the different moments and periods in which the documents were elaborated.

Therefore, from the study of primary sources – national governmental documents and CNST reports – we initially aimed to verify the frequency of the term “intersectorality” and its derivatives – “intersectoral” and “intersectorally”. However, it was evident that it hardly appeared.

Thus, based on the paper by Nascimento²³ that discusses, among other aspects, the trend/development of the concept, we reached some words that were more frequent in the documents, and that preliminarily showed some correlation

or semantic similarity with the term “intersectoriality”. It is noteworthy that, along this course, we relied on the support of qualitative analysis software NVivo.

Such terms were adopted for the continuity of the analyses and became “knots”, a nomenclature adopted by NVivo, to characterize keywords or concepts for analysis. They were: integrated actions, intersectoriality, articulation, cooperation, dialogue, collaborative, integration, interdisciplinary, interface, partnerships, and service network.

After preliminary analysis using similarity criteria (terms used interchangeably) and frequency, we decided to emphasize the terms *integrated actions*, *intersectoriality*, *articulation*, *cooperation*, and *integration* in the description of the results. Documents in which none of the listed terms appeared at least twice were discarded.

Analyzing the terminological frequency in the documents from the highlighted criteria, we observed an intense concentration of them associated with documents produced by the health sector. Thus, in the first analysis, we decided to separate the documents produced by the health sector from the others.

A content analysis was added to this preliminary analysis of the documents, where we aimed to identify in which contexts and what sense these terms were used, and whether clear guidelines for their operationalization in the daily practice of services²⁴ were available. Subsequently, the results found were compared with the area’s reference bibliography. The following documents were identified and, consequently, used for the presentation of results and discussion:

A) *Documents produced by MPS, MT, and MS:* Decree N° 3048 of 06/05/1999 – Approves the Social Security Regulation²⁵; Interministerial Ordinance MPS/MS/MTE N° 800 of 03/05/2005 – Publishes the basic text of the Draft National Occupational Safety and Health Policy (PNSST)¹⁰.

B) *Documents produced specially by the Health Sector:* First National Conference on Workers’ Health (1986)²⁶; Law N° 8080 of 19/09/1990 - Organic Health Law. Provides for the conditions for the promotion, protection, and recovery of health, the organization, and functioning of the corresponding services and other measures¹; Report of the Second National Conference on Workers’ Health (1994)⁶; Ordinance N 1679/GM of 19/09/2002 - Provides for the structuring of National Workers’ Health Comprehensive Care Network -RENAST in the SUS and provides other measures²⁷; Ordinance N° 2437 of 07/12/2005 -

Provides for the expansion and strengthening of RENAST in the SUS and provides other measures²⁸; Ordinance N° 2728 of 11/11/2009 - Provides for RENAST and provides other measures²⁹; Report of the Third National Conference on Workers’ Health (2011)³⁰; Ordinance N° 1823 of 23/08/2012 - Establishes the National Workers’ Health Policy²; Report of the Fourth National Conference on Workers’ Health (2015)³¹.

Results

The term intersectoriality was not always used as such, appearing for the first time and used more frequently in policies and other WH documents published since 2005. As highlighted, the documents sought the terms: integrated actions, articulation, cooperation, integration, and intersectoriality. A critical analysis was produced following a descriptive presentation of the results.

Documents produced by “non-health” and intersectoral sectors

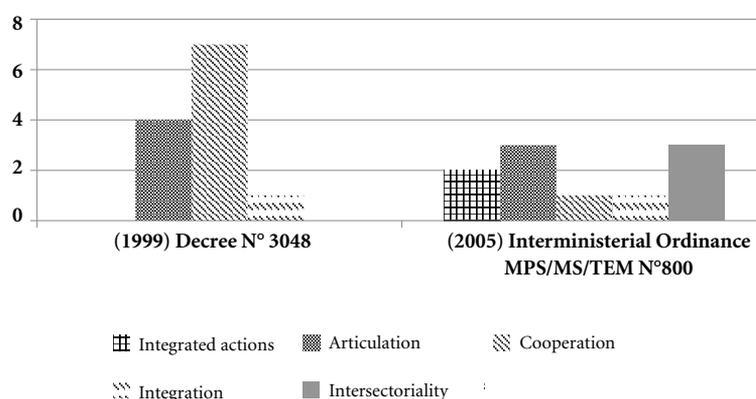
We highlight the absence of documents produced by the currently called MT, which address the terms mentioned. The few documents found were produced by the MPS, or by the three sectors, as shown in Graph 1.

The words searched sometimes addressed different concepts or suggest articulations with other sectors not covered in this study. For example, terms “articulation” and “integrated actions” refer to the strengthening of social security policy concerning civil associations, class entities, and the community, aiming, above all, to ensure the return to work.

The first mentions of intersectoral cooperation appeared in 1990, through Decree 3048, enacted by the INSS, then linked to the MPS, to obtain technical cooperation for expert evaluation. In other words, it still does not mention the integration or confluence of policies.

The INSS may, through its coordination and supervision, covenants s, terms of decentralized implementation, promotion or collaboration, inexpensive contracts, or technical cooperation agreements for collaboration in the process of expert evaluation by medical professionals from public bodies and entities of the SUS²⁵.

Interministerial Ordinance N° 800 recognized the importance of cross-cutting and intersectoral policies in this field¹⁰ explicitly. In presenting the



Graphic 1. Analysis of terms related to the concept of intersectoriality in extra-health documents (1986-2015).

base text for the PNSST Draft, the definition of the role of the Interministerial Occupational Health Executive Group was an important initiative.

The management of the PNSST will be conducted by the Interministerial Executive Group on Occupational Safety and Health – GEISAT, comprising at least representatives of the MTE, MS, and MPS. GEISAT will be responsible for preparing the Workers’ Safety and Health Action Plan and coordinating the implementation of its actions. [...] From this perspective, occupational safety and health actions require multidisciplinary, interdisciplinary and intersectoral action¹⁰.

The PNSST reinforces the proposed intersectoral articulation. It attributes MS, MPS, and MT, without prejudice to the participation of other bodies that act in the area, the responsibility for its implementation and execution, and their exclusive competencies.

Documents produced by the health sector

Regarding the documents explicitly produced by the health sector, as we can see in Graph 2, the frequency of use of the terms integrated actions, intersectoriality, articulation, cooperation, and integration increased significantly over the years. These terms have been used as synonyms, conceptual advances, generic, polysemic, and supposedly consensual expressions.

The analysis of these documents began with the First and Second CNST, in 1986 and 1994, respectively, and which were milestones in the process of elaborating National Workers’ Health

Policies. During this period, the 1990 Organic Health Law stands out.

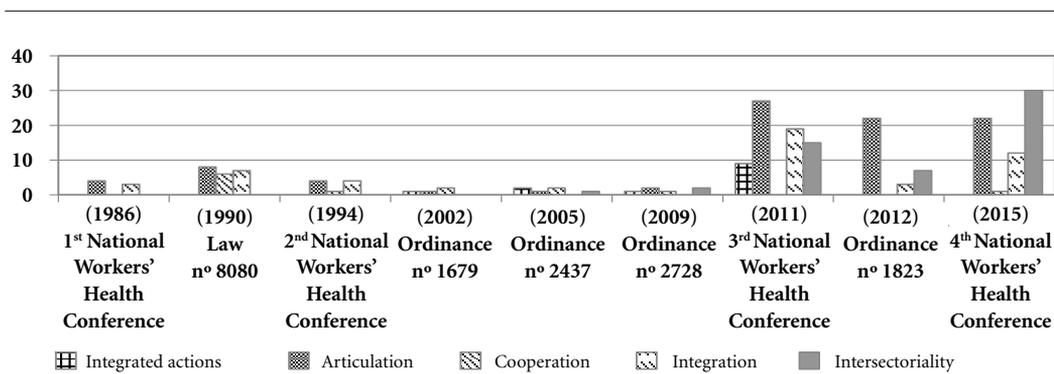
Other documents also proved to be of fundamental importance, with emphasis on the creation of the National Workers’ Health Comprehensive Care Network – RENAST, regulated in 2009, the Third and Fourth CNST, which occurred in 2005 and 2014, respectively, and the 2011 PNSST and the PNSTT, formalized in 2012.

In the analyzed documents, when the term “articulation” appears, it refers to the construction of a network of interlocutions, exchanges and joint actions (meetings, seminars, among others) between bodies, institutions, and councils with an interface with the ST (MT, Labor Public Prosecutor’s Office, MPS, social movements, education and environment, work and income, economic development secretariats, among others). In this way, at first, it would not be a programmatic integration per se, but the creation of discussion venues aimed at future integrations.

The integrated actions are necessary for the promotion of workers’ health and the prevention of injuries in practically all the documents analyzed.

The importance of integrating WH with other areas is evident since the First CNST. However, the idea of integration was very generic, covering diverse platforms that were characterized sometimes as global guidelines instead of a specific indication of actions, as highlighted below:

As for the integration of the workers’ policy with the national health policy, the following was proposed: The WH policy must be understood within the



Graphic 2. Analysis of terms related to the concept of intersectorality in health documents (1986-2015).

context of the general health policy, and be part of it. Therefore, the formulation of the policy will be part of the SUS, under the control of workers [...].²⁶

As for the integration of the WH policy with the other State Policies, the following was proposed: Articulation with a scientific and technological policy that takes into account the interests of workers; [...] Articulation with a policy that ensures the mandatory adoption of safety criteria according to more rigorous and efficient principles²⁶.

As of the Second CNST, the notion of developing joint actions, both intra, and intersectorally, is emphasized from the implementation of the Workers' Health Centers (CST) or Workers' Health Reference Centers (CRST), which have been configured, since then, as the leading public service in this field and should be open to union and popular participation in its management.

[...] The integration of Workers' Health Programs in the SUS structure, through the implantation of Workers' Health Centers (CST) or Workers' Health Reference Centers (CEREST/CRST), should be carried out with equal participation of union entities and popular organizations [...], under the underlying assumption for their full functioning: popular participation in the implantation and management; performance in the five assigned areas: surveillance, care, research, training of human resources and technical guidance to unions and businesses⁶.

In this same conference, the emphasis is placed on the centrality of the health sector in the management of these joint actions.

During this process, WH actions must be developed under the coordination of the SUS, inte-

grating the various agencies at the municipal, state, and federal levels, establishing a change in the practice of traditional surveillance and incorporating social control⁶.

As of the Third CNST³⁰, the idea that the WH field in Brazil started to consider the need to transform work organization and conditions began to materialize, emphasizing the notion that actions transcend the health field and must necessarily be cross-cutting to other fields and policies.

Also, at the Third CNST in 2005, whose report was only published in 2011, integration was pointed out as a goal and influenced the construction of the PNSST in 2011³⁰. The creation of flowcharts for interlocution between sectoral bodies and the definition of specific responsibilities were suggested, seeking to eliminate dichotomies and avoid overlaps. It should identify and publicize institutional goals among its implementing members and agents. Action planning and budgeting should also be done jointly.

As of the Third CNST, this integration is expected to be centralized by the National Health Council (CNS) through the Intersectoral Commission on Workers' Health (CIST), which should also be implemented in the state and municipal spheres.

[...] The creation of CIST in the Municipal Health Councils, especially in the CEREST headquarters, promotes workers' participation, popular movements, victims' associations, and those with sequelae of occupational accidents³⁰.

As of the Fourth CNST, held after the PNSTT was enacted, the management of political, social,

and union aspects, and the advances in the WH public policy can only be achieved through intersectoral actions.

The PNSTT is the result of several steps taken, such as the establishment of labor laws, the re-democratization movement, the Brazilian health reform, social movements, especially the Unionist [...] it is necessary to face the tension of visibility and invisibility of the health and illness situation of Brazilian workers. The entire SUS health care network must take a careful look at this reality, through strengthening surveillance, universal notification of accidents and diseases, integrating surveillance, and strengthening inter-federative bodies³¹.

Concerning Fourth CNST, actions in the areas of workers' safety and health are the responsibility of the three government sectors: Labor, Health and Social Security, with emphasis on the importance of a cross-cutting action, with their integration.

Regarding intersectoral articulations, noteworthy is that the MPS must dialogue in a more organized and systematic way with the SUS. The SUS's constitutional competency in carrying out surveillance of environments and work processes was also emphasized, as was the commitment to build, together with the MTE, articulated policies for inspection and surveillance in WH³¹.

The PNSST and PNSTT were milestones in the advancement of WH public policies, mainly due to the formalization of intersectorality in this field. The PNSTT begins to propose elements that converge for substantial changes in health work processes, in the organization of the care network and in multidisciplinary and interdisciplinary actions, which consider the intricate relationships between health and work and, thus, favor intersectoral integration.

In line with SUS principles and guidelines, this policy should be implemented from the regional to the national level. Since then, the set and the responsibility of the actors involved in its construction and the agreement of commitments around priorities that would allow it to consolidate intersectorally are more clearly outlined.

From the PNSTT, the structuring of a WH care model begins to consider the health information of each region, healthcare by line of care, the integration of actions at secondary and tertiary levels through the Health Care Network (RAS).

Thus, the idea of integration of territories is now strengthened from PHC to facilitate the identification of the productive branches most

harmful to health, the risk degrees of work activities developed in communities, and related information to establish links between work, health-disease process, and risk indicators.

The PNSTT advances the concept of surveillance by strengthening Workers' Health Surveillance (VISAT) as a tool that would articulate health knowledge and practices, both intra and intersectorally, as we can see in Article 8 of the PNSTT:

The objectives of PNSTT are to strengthen VISAT and the integration with the other components of Health Surveillance, which presupposes: Identification of the productive activities of the working population and the situations of risk to the health of workers in the territory; Identification of health needs, demands, and problems of health workers in the territory; Analysis of the health situation of workers; Intervention in work processes and environments; Production of intervention, evaluation and monitoring technologies for VISAT actions; Control and evaluation of the quality of workers' health services and programs in public and private institutions and companies².

Through the Regional Labor Superintendencies, MT's tax auditors carry out surveys and inspections in work environments, while the PMSP's CRST perform Workers' Health Surveillance actions. No documents reporting the integration between these two sectors, according to the PNSTT text, were found.

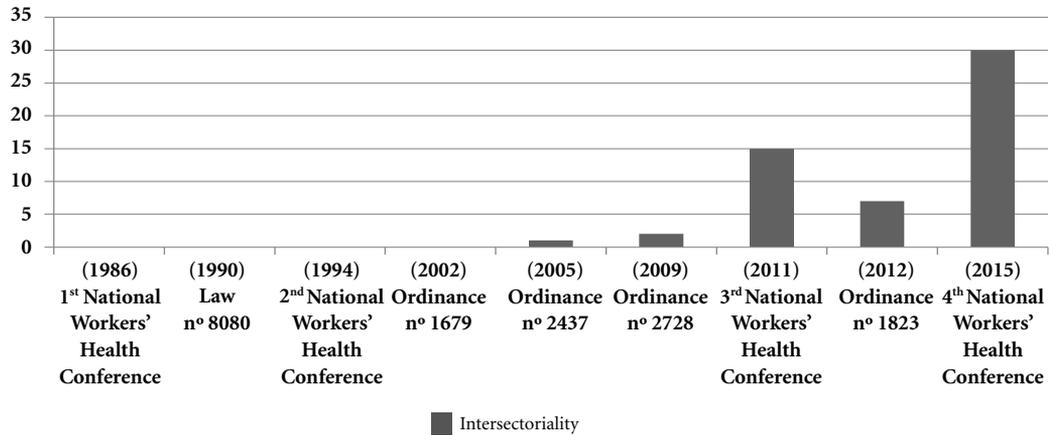
As for intersectorality, the first allusions to this idea appear in Law N° 8.080 of 1990¹, but the term appears more frequently in policies and other WH documents published from 2011 (Graph 3).

Although several terms contain intersectorality, they are being used and updated due to the recognition of their importance. However, they are mentioned as goals instead of proposed concrete actions.

Due to the scope of its field of action, the WH necessarily requires an intrasectoral, multiprofessional and interdisciplinary approach, involving all levels of care and management spheres of the SUS, and intersectoral approach, of the sectors of Social Security, Labor, and Employment, Environment, Justice, Education...³⁰.

In general, the development of integrated actions appears to be associated with the idea of greater dialogue evolving throughout the documents for the integration of sectors and areas as a whole is evident.

The role and influence of CNST in the construction of public policies in the countryside are



Graphic 3. Frequency of the term intersectoriality in documents produced by the health sector (1986-2015).

highlighted. These conferences that start at the municipal level traverse the state and advance at the national level are organized with an adequate representation of the sectors involved based on the representation of delegates. Excerpts from the reports produced at these conferences are reproduced in the primary documents and policies that follow them.

Discussion

Since the 1980s, the concept of intersectoriality has been incorporated into WH public policies, and its meaning has been progressively constructed.

Despite recognizing the inseparable character of these actions for the development of the health and work field, the lack of clear guidelines for their implementation in the daily practice of services has been recurrent, and their effective exercise brings challenges to the sectors involved. Serrate⁷ highlights that one of the conditioning factors of intersectoriality refers to the strength and role of the state and governments, reaffirming the need for clear, concrete actions in relevant laws and regulations.

The proposed guidelines for the development of intersectoral actions within WH policies are sometimes generic and address actions in all spheres of living (work, environment, quality of life, justice, and health). This situation reveals a generalization and expansion of the field of health and work, which ends up disseminating it

to other spaces and sectors, characterizing it as cross-cutting. However, at the same time, this generalization may not hold any particular sector accountable or dilute the focus of actions that thus become less concrete. At the same time, it brings to the sphere of health a set of problems and responsibilities that transcend it in the strictest sense.

In contrast, international and national studies point out that health issues in general and WH specifically, due to their high complexity and multicausality, can hardly be solved by actions exclusive to the health sector. In this context, they highlight the intersectoral actions as enablers of comprehensive and participatory approaches to consider the set of factors that determine the health conditions of the population^{7,32-34}.

Warschauer and Carvalho²⁰ draw attention to the different understandings of the sectors as to what a partnership is, what the respective managing body would be, and the implications of implementing and managing intersectoral projects. In other words, the lack of definition of responsibilities and the degree of direct or indirect involvement of the different actors in the process ends up hampering intersectorality¹⁹.

Serrate⁷ points out that the organization of society or institutions, bodies, and professionals involved is another condition for intersectorality: each one should know their role, work objectives, and actions under their care.

In general, the political and technical unpreparedness of managers and professionals to assu-

me intersectoral actions, besides administrative-bureaucratic activities hindering the integrated execution of actions, is also pointed out by some authors as aspects that hamper these practices^{7,17,33,34}.

The difficulty of building a common axis concerning the actions and the objectives of these WH-related actions is still pointed out as a challenge, which includes, for example, vertically hierarchical management, with different political and control forces between the sectors underpinning the different spheres of public policies^{15,16,21,23}.

Centralized management structured in a pyramid format for each sector hinders integration and, consequently, intersectorality²¹. While the health sector is designed to operate in a network, some studies highlight that the structure of public administration, at all levels, is an important limiting factor for the robust construction of a sustainable intersectoral base¹¹.

Added to this is the unpreparedness of the managers involved in the WH, which is reflected in the transfer of the implementation of the intersectoral action to the action's agents, leaving them as the sole performers of these actions. Depending on workers and local policies, these actions can be more or less integrated. This finding further highlights the limits of intersectorality and, sometimes, the integration of actions within the same sector.

However, international experiences have highlighted that intersectoral action results increase with the decentralization of these processes and their approximation at the local and community level, where the sectors have sufficient power and freedom of action to detect and address the problems^{7,33,34}.

A process of centralizing actions around the Brazilian health sector, initiated with the social movements that led to the enactment of the SUS, has also been noted. The spearheading role of the health sector is observed from the formulation of policies to the leadership of programs and actions, and this leadership also implies an expanded health concept and the development of actions that fall under the responsibility of the SUS and that, with this, come under the aegis of its mechanisms and financing limits. This process reached its peak with the creation of RENAST in 2002⁵.

Another complicator to intersectorality is the lack of funding to implement these actions,

which ends up favoring/reinforcing health's role, as SUS ends up financing several actions, such as, for example, workers' health surveillance.

This centralization around health can adversely affect expectations. That is, it ends up isolating and inhibiting other proposals, discouraging precisely what we seek to strengthen – intersectorality and co-responsibility. Likewise, the challenge for the effective implementation of intersectorality implies shared participation and responsibility, including financing these actions.

However, it is essential to emphasize that this *modus operandi* is in line with the prerogatives of the World Health Organization, which, in 2013, when promoting its Eighth Global Health Promotion Conference, reaffirms the need to consider people's health as a cross-cutting axis to any public policy. In this context, the Health in all policies (HiAP), the guiding document produced at the time, emphasizes the consequences of public policies on health systems, health determinants, and social well-being. It also recognizes that governments are faced with some priorities and that health and net or intangible assets, cannot be secondary, but must take precedence over other policy objectives³⁵.

Finally, it is essential to emphasize that, as Serrate and Abreu³³ point out, talking about a model is extremely easy, but contradictions between interests, powers, viewpoints, policies, social groups, and needs are faced when putting it into practice.

Conclusion

Despite the evolution of the concept of intersectorality in WH policies and the growing participation of different sectors in this construction, few clear proposals on the effectiveness of this practice among managers and among the workers who make up the field are noted.

A point to be highlighted as a limitation of this paper is the emphasis on studying federal policies exclusively in the fields of work, health, and social security. Since decentralization and regionalization are guidelines of these same policies, and in national studies, difficulties of guidelines that assist in the operationalization of intersectoral actions are evidenced, they may be occurring in some areas of the country, or are being addressed differently in specific municipal and state policies.

Collaborations

S Lancman: coordinator of the thematic project, responsible for this stage of the research and one of the leaders in the elaboration of the paper. TO Rocha: scientific initiation scholarship holder for the thematic project and participating in all stages so far carried out and the preparation of the paper). TA Jardim: co-author of the project and participant in this stage of the research. JO Barros: co-author of the project and co-responsible for this stage of the research, and one of the leaders in the drafting and review of this paper. MTB Daldon: collaborator of the project and whose participation was essential in this new drafting of the paper.

Funding

Fundação de Amparo à Pesquisa of the state of São Paulo (FAPESP).

References

1. Brasil. Lei nº 8.080, de 19 de setembro de 1990. Dispõe sobre as condições para a promoção, proteção e recuperação da saúde, a organização e o funcionamento dos serviços correspondentes e dá outras providências. *Diário Oficial da União* 1990; 20 set
2. Brasil. Portaria nº 1.823, de 23 de agosto de 2012. Institui a Política Nacional de Saúde do Trabalhador e da Trabalhadora. *Diário Oficial da União*; 2012.
3. Lancman S, Szelwar LI, Barros JO, Jardim TA. Projeto de Pesquisa: Construção da Intersetorialidade no Campo Saúde e Trabalho: perspectiva dos profissionais inseridos na rede de serviços do município de São Paulo. Processo FAPESP 2014/25985-2 (mimeo).
4. Minayo-Gomes C, Thedim-Costa SM. A construção do campo da Saúde do Trabalhador: percurso e dilemas. *Cad Saude Publica* 1997; 13(Supl. 2):21-23.
5. Lacaz FAC. Saúde do trabalhador: vinte anos de história e trajetória. In: *Conferência Nacional de Saúde do Trabalhador: Trabalhar, sim! Adoecer, não!* - Coletânea de Textos. Brasília: MS; 2005.
6. Brasil. Ministério da Saúde (MS). *Relatório Final da 2ª Conferência Nacional de Saúde do Trabalhador*. Brasília: MS; 1994.
7. Serrate PCF. Comprensión conceptual y factores que intervienen en el desarrollo de la intersectorialidad. *Rev Cubana Salud Public* 2007; 33:2.
8. Magalhães R, Bodstein R. Avaliação de iniciativas e programas intersetoriais em saúde - desafios e aprendizados. *Cien Saude Colet* 2009; 14(3):861-868.
9. Tess BH, Aith FMA. Intersectorial health-related policies: the use of a legal and theoretical framework to propose a typology to a case study in a Brazilian municipality. *Cien Saude Colet* 2014; 19(11):4449-4456.
10. Brasil. Ministério do Trabalho e Emprego. Ministério da Previdência e Assistência Social e Ministério da Saúde. Portaria Interministerial nº 800, de 3 de maio de 2005. Aprova a Política Nacional de Segurança e Saúde do Trabalhador. *Diário Oficial da União*; 2005.
11. Ornelas AL, Teixeira MGC. Intersetorialidade ou diálogos setoriais? Reflexões a partir da experiência do Projeto Teias-Escola Manguinhos, Rio de Janeiro. *Saude Debate* 2015; 39(106):659-670.
12. Koga D. *Medidas de cidades: entre territórios de vida e territórios vividos*. São Paulo: Cortez; 2003.
13. Silva KL, Sena RR, Akerman M, Belga SMM, Rodrigues AT. Intersetorialidade, determinantes socioambientais e promoção da saúde. *Cien Saude Colet* 2014; 19(11):4361-4370.
14. Sposati AO. Gestão pública intersetorial: sim ou não? Comentários de experiência. *Serv Soci Soci* 2006; 27(85):133-141.
15. Monnerat GL, Souza RG. Da Seguridade Social à intersectorialidade: reflexões sobre a integração das políticas sociais no Brasil. *Rev Katal* 2011; 14(1):41-49.
16. Azevedo E, Pelicioni MCF, Westphal MF. Práticas intersetoriais nas Políticas Públicas de Promoção de Saúde. *Physis* 2012; 22(4):1333-1356.
17. Veiga L, Bronzo C. Estratégias intersetoriais de gestão municipal de serviços de proteção social: a experiência de Belo Horizonte. *Rev Adm Publica* 2014; 48(3):595-620.
18. Junqueira LA. Intersetorialidade, transectorialidade e redes sociais na saúde. *Rev Adm Publica* 2000; 34(6):35-45.
19. Ribeiro RC. A construção de um município saudável: descentralização e intersectorialidade - experiência de Fortaleza. *Saude Soc* 1997; 6(2):47-54.
20. Warschauer M, Carvalho M. O conceito "Intersetorialidade": contribuições ao debate a partir do Programa Lazer e Saúde da Prefeitura de Santo André/SP. *Rev Saude Soc* 2014; 23(1):191-203.
21. Rezende M, Baptista TWF, Amâncio Filho A. O legado da construção do sistema de proteção social brasileiro para a intersectorialidade. *Trab Educ Saude* 2015; 12(2):301-322.
22. Shankardass K, Solar O, Murphy K, Greaves L, O'Campo P. A scoping review of intersectoral action for health equity involving governments. *Int J Public Health* 2012; 57(1):25-33.
23. Nascimento S. Reflexões sobre a intersectorialidade entre as políticas públicas. *Serv Soc Soc* 2010; 101(1):95-120.
24. Cellar A. Análise documental. In: Poupert J, Deslauriers JP, Groulx LH, Laperriere A, Mayer R, Pires A. *A pesquisa qualitativa: enfoques epistemológicos e metodológicos*. Petrópolis: Ed. Vozes; 2012.
25. Brasil. Ministério da Casa Civil. Decreto nº 3.048, de 6 de maio de 1999. Aprova o Regulamento da Previdência Social. *Diário Oficial da União*; 1999.
26. Brasil. Ministério da Saúde (MS). *Relatório Final da 1ª Conferência Nacional de Saúde do Trabalhador*. Brasília: MS; 1986.
27. Brasil. Ministério da Saúde (MS). Portaria nº 1.679/GM, de 19 de setembro de 2002. Dispõe sobre a estruturação da RENAST no SUS e dá outras providências. *Diário Oficial da União*; 2002.
28. Brasil. Ministério da Saúde (MS). Portaria nº 2.437, de 7 de dezembro de 2005. Dispõe sobre a ampliação e o fortalecimento da Rede Nacional de Atenção Integral à Saúde do Trabalhador - RENAST no Sistema Único de Saúde - SUS e dá outras providências. *Diário Oficial da União*; 2005.
29. Brasil. Ministério da Saúde (MS). Portaria 2.728, de 11 de novembro de 2009. Dispõe sobre a Rede Nacional de Atenção Integral à Saúde do Trabalhador (RENAST) e dá outras providências. *Diário Oficial da União*; 2009.
30. Brasil. Ministério da Saúde (MS). *Relatório Final da 3ª Conferência Nacional de Saúde do Trabalhador*. Brasília: MS; 2011.
31. Brasil. Ministério da Saúde (MS). *Relatório Final da 4ª Conferência Nacional de Saúde do Trabalhador*. Brasília: MS; 2015.
32. Kranzler Y, Davidovich N, Fleischman Y, Grotto I, Moran DS, Weinstein R. A health in all policies approach to promote active, healthy lifestyle in Israel. *Isr J Health Policy Res* 2013; 2(1):2-16.
33. Serrate PCF, Abreu EAG. La intersectorialidad y el desarrollo de la Salud Pública en Cuba. *Rev Cubana Salud Publica* 2009; 35:1.

34. Pérez AGA, Fariñas AG, Salvá AR, Gorbea MB. Voluntad política y acción intersectorial: Premisas clave para la determinación social de la salud en Cuba. *Rev Cubana Hig Epidemiol* 2007; 45:3.
35. World Health Organization (WHO). *Health in all policies: Helsinki statement. Framework for country action*. Helsinki: WHO; 2013.

Article submitted 16/06/2018
Approved 11/02/2019
Final version submitted 13/02/2019